Adobe Population Health – 5-Star Diabetic Initiative Plan

Proposal: APH is proposing an integrated interdepartmental and comprehensive approach to management of uncontrolled diabetes; HbA1c > 9.0.

Our population is known to have barriers and challenges to care including, but not limited to, health literacy, access to care, financial security, and food security.

Within this integrated and comprehensive approach, we will implement **7 basic components** to our diabetic management program which will improve the member's overall quality of life and reduce disease burden and associated complications.

The 7 Basic Components are:

1. **Healthy eating –**
   - Understanding nutrition labels
   - Carbohydrate counting
   - Meal planning
   - Low-cost options
   - Access to fresh foods
2. **Being active –**
   - Addressing barriers to exercise
   - Safe start to an exercise regimen
   - Identifying free and safe ways to exercise (Silver and Fit benefit)
3. **Monitoring –**
   - Self-monitoring (fingerstick vs. CGM)
   - Increasing control of A1c
   - Timing and frequency
   - Incorporating into daily routine
   - Importance of PCP follow-up
4. **Take meds –**
   - Evaluating barriers to adherence
   - Complexity of the routine
   - Comorbid depression/BH
   - Difficulty remembering
   - Cost and/or access to prescriptions or refills
5. **Problem-solving –**
   - Problem-solving skills to help member adapt to blood glucose variations – managing high and low readings
   - Finding alternative solutions as needed
6. **Reducing Risk/Complications –**
   - Reducing risk through smoking cessation
   - BP management
   - Statin use for members with diabetes
   - Preventative screenings (eye exams, foot exams, nephropathy screens)
7. **Healthy Coping –**
   - Emotional well-being
   - Member engagement
   - Motivation for change
   - Stress management
   - Mental health education

The Plan

- ✓ **Initial Target**
  - Members on the Excel spreadsheet from the clinical pharmacist (Laura Hanson) received Jan 5, 2022
  - Collective goal is to focus on **interventions** rather than frequency of testing
- ✓ **Referral to Dietician**
  - Healthy eating with diabetes considering member's access to affordable and fresh foods, regional culture/cuisine, meal planning, carb counting, nutrition label education
  - Reinforcement of healthy eating by CM team
- ✓ **Referral to ICM/SW**
  - Educate, reduce barriers to care, depression remission
  - Provide **Zone** tool and educate during the in-home visit to improve patient monitoring and problem-solving skills for blood glucose out of goal range
  - Increasing member engagement
  - Provide ongoing education and support
- ✓ **Referral to endocrinologist and their diabetic educators (as access to care allows)**
  - Telehealth or in-office visit
  - CM team to coordinate referral and appointment
- ✓ **Primary Care Provider Engagement**
  - Coordinate and collaborate with PCP and office to ensure PCP support
  - Member adherence to medications and appointments
  - Assist with CGM prior auth as needed
  - Coordination of referrals and treatment plans
- ✓ **Clinical Pharmacist**
  - Continued collaboration with medication and claims reviews to increase medication adherence and evaluate for needed changes/concerns
  - Pharmacy to reach out to provider with considerations for medication changes
  - Integrate formulary in decision-making and low-cost options/programs
- ✓ **Continuous Glucose Monitoring (CGM)**
  - CM to evaluate each member to determine if member is a candidate for CGM
    - 1) testing 3 or more times a day
    - 2) insulin administration 3 or more times a day
    - 3) frequent insulin adjustments or medication changes
  - If member is a candidate, Physician Engagement team to educate provider on appropriate documentation needed to submit for prior auth
- ✓ **Testing Frequency**
  - March (initial list)
  - October
- ✓ **Podiatry Referrals for foot and nail care**
  - CMs to help coordinate referrals and provide education
- ✓ **Preventative Screenings**
  - To reduce risk and complications
    - eye exam
    - foot exams
    - nephropathy screening
    - PAD check
    - education - teach self-foot exam (using a mirror to look at bottom of the feet)
      - NPs to have monofilaments
      - coordinate f/u appointments with PCPs for any positive screenings
- ✓ **NPIHA**
  - CM team will send **Teams** message to IHA team to schedule NPIHA during their initial outreach to the targeted member
  - NPs to have monofilaments
- ✓ **APG**
  - DM program being created for APG members, if unable to complete intervention through outreach above:
    - referral to APG to work with members and support PCP - or APG becomes the PCP.
    - Referrals to go to Dr. Sibrava for review first.
    - Note: APG will not go in short-term and make medication changes if still actively involved with their PCP, this will cause provider and member abrasion.
- ✓ **Member Engagement**
  - Important part of intervention is member engagement in their own self-care and treatment/care plan
  - ADA Tool Kits to be used as tools
- ✓ **Understanding A1c**
  - A1c is also known as hemoglobin A1c, glycated hemoglobin, or HbA1c
  - A1c is the average blood sugar over a period of three months
  - A1c monitors how well blood sugars have been managed over a long period of time.
  - Example:

If you're A1c =	Then your average daily blood sugar =
6	126
6.5	140
7	154
7.5	169
8	183
8.5	197
9	212
9.5	226
10	240

✓ **Online Resource: A1c and Blood Glucose Convertor**

https://professional.diabetes.org/diapro/glucose_calc#:~:text=The%20relationship%20between%20A1C%20and%20eAG%20is%20described%20by%20the,X%20A1C%20%E2%80%93%2046.7%20%3D%20eAG.